The problem being these is that there's deleterious neonatal outcomes and maternal outcomes in this country and we're very, very well aware of them and they are getting worse.

And this is, there is more urgency than ever to solve for this problem because we are seeing largely preventable occurrences increase. In fact, I think this statistic came from the CDC, 80% of all maternal deaths are preventible.

80, and we have some of the highest rates of maternal mortality in this country. Same thing with infant mortality. And the infant mortality and vulnerability comes from those neonatal experiences and the first health care system that anyone enters into is the inner uterine environment.

So the inter-uterine and environment is first healthcare system, that we all experience. It is most powerful tone setting stage that Hello and welcome to the podcast.

This week we interview Emily Ribbomb. She is one of the co founders of Grow Baby. in pediatrics, and they've been on an incredible journey to prove the impact of nutrition in early childhood outcomes, to proof that this can be delivered in a Medicaid population.

And what you're going to hear is a new study that they have put out and what the effect is and how it's giving them momentum. There's so much to learn from this podcast, but one of the big things I want to get across is what does it take to make a real impact in medicine with the tools that we have here?

in functional medicine, and this is a masterclass in that. Enjoy. So a warm welcome to the podcast, I think, actually, for the first time. Emily Ridbom, welcome, Emily.

Thank you so much, James. I'm thrilled to be here. All these years and we've never jammed. No, we know each other for like a decade plus. It's been a minute.

Well, look, I'm super excited today and the purpose of why this came around is I've been following on social media and I'd be following the Grow Baby project for a long time because I think everyone involved in functional medicine recognizes that the best time to intervene is like at the first possible moment or even before.

because you just see the things that happen at the very beginning have an effect all the way through. That's the area that you're playing. What I'm excited about is just to help the audience understand a little bit more about your work and what some of the implications are for our industry and for healthcare and the evolution of medicine.

Why don't we just start for the right now and share a bit about the study and and why you think it's important. All right, thank you, James. Well, so we, as you know, we were able to publish at the end of February through the Journal of Personalized Medicine and really that study represents the culmination of about 13 to 14 years of our work where we we're iterating on really the supplied perinatal nutrition model, the grow baby model.

within an insurance based clinical setting and family practice integrated care in a rural part of the United States. So this is, you know, it would qualify in many instances as a maternal care desert in some instances for some folks that walk through the doors of food deserts certainly associated with vulnerabilities in and around equity, social determinants of health.

So this population that we're speaking to in our paper and that continue to work with, these are not folks that typically have a ton of resources to them.

One of my favorite things about what functional medicine and systems biology does is that allows us to find creativity where otherwise maybe it feels that we may get stonewalled.

But of course that requires integration of different professionals within care models like a nutritionist as an example. And so Grow Baby's work has put nutrition at the forefront of the conversation around biology and really finding physiological patterns that emerge as nutritional insufficiencies and deficiencies far before sometimes even biomarker status changes, through nutrition physical exam findings, you know through symptoms and challenges.

And you you notice you're a dad, there's a lot of challenges that can come just simply with being pregnant because of the amazing amount of life-giving force that this maternal body has to has to pass along to their kiddo.

And so our work has now spanned across kind of really three key care models. So we started actually with group medical visits. As you know, community cure.

There's a big component of healing that happens when you integrate community. Number two, because of the COVID time period, we had to utilize the up and coming telemedicine, telehealth concept in virtual.

visits, and then the third was a fully hybrid model, or excuse me, a full virtual model. So we had the group medical, we have the hybrid where we've had in-person, the single visits with the virtual and the then virtual care model and that virtual-care model was actually applied, albeit in our small but mighty cohort in Nevada, was applied in a 100% Medicaid population and it was funded with preventative dollars by a Medicaid care organization.

And what is, I think, pivotal about the work that we continue to do is although in our study, the majority of that cohort came from our organ population.

So those folks who walked through our own clinical doors. The next iteration was really represented in a completely different population and one that showed equal vulnerability to our Oregon population in terms of obesity rates, drug use rates alcohol use, rates and really just what we are starting to understand the set point of vulnerability of most women walking through the door with their pregnancy, you know, we're seeing that.

Even with diet, even with supplementation, we're seeing really big deficiencies and main key micron macronutrients that are setting the stage for complications where otherwise if there was a nutritionist in the loop, if someone was sitting there as an extender to the obstetric care that is being given in United States now, many of those patterns would emerge as preventative and we could anticipate them.

And so I think for us, what we continue to be so thrilled about is that no matter how we apply this work, we seem to get rates of preterm birth that are far lower than anything that we see in the United States.

Same thing with GDM. Same thing with preeclampsia, hypertensive disorders of pregnancy, and then babies that are born too large and too small. So both large for gestational age and small for just gestation age.

And I think it's because we've focused on limiting and ameliorating that gap of nutritional deficiencies with using Parts of the system that exists for us now, James.

So the part that we can get labs covered with the insurance model where we Can utilize warm referral networks to registered dietitians and nutritional professionals and so that's what makes us so excited It's not an indictment of a system as it stands It is leveraging the creativity that the System actually affords us Now and really trying to bring more power to all care providers who can tap into it How did you decide what the intervention was going to be in those cohorts?

And what was the sort of diagnostic process to understand, like, what it was gonna be for everyone? What was it gonna individualize, depending on the information that came in?

That's a great question. So the way that the grow baby model works, or in this case is called standard of care plus within the papers, just so we can orient with language there.

But the wave of the girl baby care model, works is that actually the very first tenant of what we did the the first structuring of our nutrition program was what.

Changes occur by trimester, both for the fetus and the mother that require heightened micro and macronutrient interventions, right? So it's not just what's happening with fetal development and growth, all the way from organogenesis in the first trimesters to really the components of neuroplasticity and neuronal growth in the third trimester to simplify it, right?

But also what's happening with the mom that impacts her resilience, that changes her ability to be able to engage in a lifestyle measure that helps optimize this time period.

You know, I think it's very easy to focus so much as a parent and as as system on the baby, because that child is growing, it's developing, its vulnerable.

And so we have to ensure that we're doing everything we can for that baby. But in the meantime, if the measurement of our success is only in outcome of the birth, and we are not measuring the success of how we supporting the mother too, then I believe that's a failing.

of how we're approaching this. And so what we utilized was, what's happening with fetal development? What's with maternal complications, symptoms, and challenges that are common, but aren't inevitable, right?

Just because of the physiological process of growth and pregnancy doesn't mean that we can't anticipate the needs. So that's the basis of we approached it first by trimester.

Every plan changes by trimester, so every mom gets a good base plan of low glycemic index. macronutrient ratios, so that 40% carbohydrate, 30% protein, and 25 to 30 grams of fiber.

That's a big significant change over really what we know most Americans are maybe getting 8 grams, if on a good day, probably less than that. A big key modulator of that microbiome right?

And then of course on the top of that focusing on micronutrients that we know become more and more depleted over the course of pregnancy and not just to point a finger at hemodilution because I think that in some ways is an easy excuse and it's actually what some of the limitations of a research are showing is that, we don't necessarily have great reference range values for some these micron nutrients and so it is easy to just chalk it up to oh well it just you know the deficiency exists because of hemo dilution when really We have a mom who was just really struggling and needs more support.

And so we emphasize food first, of course, in all things. We layer on top with micronutrient needs based on symptoms and challenges, nutrition, physical exam findings, but also biomarkers.

So we do utilize kind of a key set of biomarks for everybody, being the CDC with autodifferential, a CMP. 25 hydroxy D, zinc, total and free carnitine, and also maternal DHA.

So not an omega-3 index, but specifically kind of measuring maternal dha, which isn't going to give us quite as much of that omega index similar to the way that when you measure hemoglobin A1c, it gives you kind representation, an omega index would do the same thing.

It gives us a little more longitudinal leverage to understand, but the Maternal DHA gives a good understanding of compliance and sufficiency in real time, so maybe over weeks.

And then we utilize, in the Oregon cohort, we primarily utilized two key SNPs. associated in three, in some instances, associated with methylation, one carbometabolism being MTHFR, C677T and A1298C, and then the haplotypes of COMT, so that catechol-O-methyltransferase.

In the Nevada cohort, we brought in a much larger nutrigenomic array, that allowed us to tailor interventions even further. You know what, James? What was so cool about that is that These moms were floored to learn this information about themselves.

In many ways, it reinforced like, oh my gosh, that explains why I feel X when I get stressed, or that means why feel x when, you know, I don't have enough vitamin D.

You know? So I think for these moms, It was not dissimilar from, from like reading an astrology calendar or zodiac sign, getting some free insights into themselves that allowed them to say, okay, this gives me a reason to implement this information about myself because I really do need it.

So it takes this concept of like general nutrition support and really makes it precise and personal. And therefore, drives cognitive behavioral theory, which is, I feel competent enough, the opportunity is given to me, and I'm motivated enough to really make this change, let alone the fact that I would say the pregnant population is maybe one of the most motivated populations of folks I've ever worked with in being a board-certified holistic nutritionist for 15 years.

I worked across chronic disease, you know, across the gambit in many ways. And so it's a pretty exciting time to think about how this model of using food first, layering in nutrients, utilizing existing biomarkers, bringing in precision omics on top of and integrated into allopathic care, because it is not meant to replace or usurp.

It's meant live in parallel to extend and create that compassionate care model. For us, it's exciting. There's limitations to it, of course, too. I mean, I think it is important to recognize that.

We've not run a principal component analysis with this, meaning that which part of the grow baby model drives these outcomes. Is it the access to the nutritionist?

Is the tailored nutrient supplementation? is it testing? But I Just like systems biology, the secret and the sauce is that it's probably all of it. It's likely that holistic approach that allows this to be so powerful, but also overwhelming to people when they hear this.

Like, how in heck do I do this? So you asked another question. How do you go about doing this, right? And so I think Leslie has to answer this question a lot, Dr.

Leslie Stone, who is the obstetric side of the grow baby model. Because not everyone is going to have a nutritionist at their fingertips, right? So how do you create, how does an obstetrition or any provider who was working in this population How did they go about establishing a referral?

Establishing the diagnosis to get the referral done, right? And so that's where I think kind of the core next step of our work needs to live is really showing people how to do this in their own in their own care practices because it's utilizing things like I said, the CDC without a differential, to CMP and a select set of biomarkers to begin the process of being able to attach a nutrient diagnosis to get that referral to the registered dietitian or nutrition professional.

So, you know, that's kind of the next iterative step of this, I would say. seems like if you didn't do this, you get the outcomes that you got across the rest of America and Medicaid populations, right?

And those are measurable in terms of the costs of all those conditions that showcasing the value of these kind of interventions in a context of things that you're avoiding, like these downstream consequences.

Because surely it makes sense to me that this would be the greatest way to measure the success is like avoiding all of this, at least near term complications, nevermind the autoimmune disease when you are 35, because you didn't get the right nutrients when were minus two months.

Just wanted to take a moment to thank our mission partners for helping bring this podcast to you. As you know, we are in the business of building a network of clinics that can reverse cognitive decline and our partners in that are Organizations, you can find out more if you go to goevomed.com and look at the mission partners.

But first and foremost, Truenura. If you got to truenura.com, we can get a demo. This is the underlying software

that will connect this network of clinics.

And we have an incredible mastermind session, a lot of cool stuff coming out of that company. You can see here, Fullscript, thanks to FullScript with Full script, where we're gonna help you take advantage of the tools that they have.

to compete with things like ChatGBT and Function Health. It's going to be awesome. Go to goevomed.com slash full script. Big Boost Marketing. If you need patients for your clinic or if you have any marketing needs, go evomed dot com slash big boost is our premier supporter in that world.

And then please also check out Freedom Practice Coaching, built and scaled a very successful brain health practice and has been instrumental in helping practitioners with the non-clinical aspects of running a practice doing this.

These are our mission partners. these are people that I know well, these people are top of their sphere and really excited to bring you the rest of the podcast.

Enjoy. Yeah, it's a great concept to speak to, right? Because I think the problem exists across MCOs. It exists, across government entities. Exists across hospital systems, meaning the problems being these is that there's deleterious neonatal outcomes and maternal outcomes in this country and we're very, very well aware of them and they were getting worse.

And this is There is more urgency than ever to solve for this problem because we are seeing largely preventable occurrences increase. In fact, I think this statistic came from the CDC, 80% of all maternal deaths are preventable.

80. And we have some of the highest rates of maternal mortality in this country. Same thing with infant mortality. The infant's mortality and vulnerability comes from those neonatal experiences and those neo-natal outcomes that are setting the stage.

I'll repeat myself because I said this to you in the beginning, but The first healthcare system that anyone enters into is the inner uterine environment.

So the interuterine and environment is first health care system, that we all experience. It is most powerful tone setting stage that, we have and I think The acknowledgement that the Grow Baby standard of care plus model is trying to bring forward is this, is that this isn't just about the prevention of these outcomes.

Although, James, to your point, that is what piques the interest of MCOs. It's what peaks the interests of hospital systems. They say, well, if I can decrease these outcome, then ultimately I'm talking about an economic impact that's of interest to us.

Yeah, you come for the economic impact and you stay for network sufficiency throughout your life. That's right. And you know, it was so funny because for so long, James, we were really beating the mission drum as much as possible and then we had really powerful insight from our work in Nevada and really from really some close colleagues that said, emphasizing the economic model, the cost effective analysis ratio, so the quality adjusted life you're saved, that is not an abandonment of mission.

It's using the language to speak to the stakeholders so that they can hear it. And so, and that's really what this is about. The same solution exists for all the stake holders who care, you just have to change the languaging of it, to allow them to sit up and listen, because to your point, James, a preterm birth in the United States costs $65,000, and that is the singular event.

That's not talking about the implications of the cost of pre-termbirth over the course of even the child's first year of life, let alone the emotional, spiritual, mental strain, challenge that can happen from having a preterm birth.

child within a family unit or within the mother or whomever it is, the caregiver. And so I think it's important to

recognize, too, that that singular economic event is the tip of the proverbial iceberg, right?

This is not just about preterm birth. It really is talking about changing the entirety of that trajectory of health of person and the system as a whole.

I often actually, I understand the utility of utilizing something like a randomized controlled trial. I really do, understand, the value of it, except for in this type of care, we unfortunately have a long history of seeing how well we do it when we are just applying kind of current standard of care and we're not touching the needs of this maternal population in this country in the least.

And so, you know, this is for me trying to bring some of the highlight forward into like, how can the system work for us? How can we utilize and pull on the tangible parts of a system that can bring this type of peer forward?

Yeah. That's a great point. And I think we've got plenty of data about what the standard of care does. One thing that you might find interesting, so I put an event last year and I had two pediatrician friends who have a practice down the road, training functional medicine, like have an incredible practice.

They work with a lot of chronically ill kids, but they also have this sort of like trusted patient direct primary care population. And one of the graphs that they put up when they were doing their presentation was, what is the percentage of kids that have these chronic illnesses in the country?

What are the percentages of kid that had these conditions in California? And then what are percentage kids who have this conditions, in this practice?

And ultimately, the eye-opening thing is that that third bar graph does not exist because all the kids are healthy. And that's what it looks like. They do things there.

One of the innovations that they came up with was what they call the Bambino visit, which was essentially like a group visit for the first 18 months of care where you'd actually meet a cohort of other parents and do this healthy stuff along the way.

There's not so much prenatal just because it's a pediatric practice. But it's incredible. I think you're right to say that at the beginning, you need the mission because you want to get people engaged.

You don't have resources. where you have to sell the people who hold the purse strings, and they need to understand that this is gonna help them. And ultimately, I guess that's what I wanted to just dive into here, because this isn't a life's work for you, right?

You have your father and mother functional medicine royalty, you are sort of birthed into this milieu, You take on this project that now is over a decade old, And I'd love for you to speak to what it takes to actually change something significant, because you've got this Oregon cohort, now you got the Nevada cohort.

You got a new North Carolina cohort where there's going to be even more engagement into the system as it is. You have this virtual delivery system with the plus that could be prescribed by all of those OBGYNs that don't have a nutritionist friend and they haven't developed that relationship.

the pathway towards solving this problem exists. And we're about the same age, I think, right? You still got some juice in the locker, so this could happen in one lifetime.

But you're in in middle of it now. So I'd love for you to share just your thoughts on that because I feel the from you that I feel when I go to functional medicine conferences and see people operating it, I fell it right now with the doctors that are involved with reversing cognitive decline.

At the other end of the spectrum, but another example of where the economic savings are potentially so significant because of cost of one extra month of of memory care, right?

But ultimately, in order to get the people to play ball, there has to be a moment where you put it into dollars and cents and represent that this is a healthy investment all the way around.

Absolutely. Well, and I'll just divulge my age because I actually find the irony of the parallel path of developmental programming of health and disease to actually coordinate exactly with my lifespan time.

So in 1986, David Barker and some of his colleagues, of course, published the Dutch Famine Studies, right, which really was the impetus of this concept of Developmental Programming of Health and Disease or the transgenerational programming of resilience is kind of how I like to think of it.

So I am as old as DOHAD, so I'm almost 40. And I started this pathway really having grown up in it, right? But functional medicine and really systems biology entered into my parents' working ethos very, very early as family practice physicians, Leslie, my mom being a family-practice obstetrician, Michael though, Dr.

Michael Stone also having delivered babies too earlier in his career. Both of them have this touch point of this womb, the womb magic in them a bit. But over the course of their clinical practice, when they started integrating nutrition very earlier, in their practice I realized that I wanted to become a nutritionist because of the time I got to spend with people and also understanding that nutrition is the one thing all of us share in common, no matter who you are, across the world.

And I use this line a lot, but on average, an adult human eats about 2000 pounds of food in a year. And that means we get 2000 of opportunity to try to optimize ourselves.

Like that's a lots and there's lot of grace in that statement. I really wanted to push back against the societal pressure of that having to be perfect, especially during a time period when pregnancy, when, you know, nausea is a bummer.

Right? And fatigue is intense and it just feels like no matter what you do, you are failing this baby and failing yourself within this pregnancy time period because societal pressures, the messaging is discordant, it's misunderstood, It's not valued, its reactive, Its triggering.

And so for me, I realized that that is really where I wanted to put my time in my heart was how do I create empowerment around the pregnancy, time, period, but really the preconception postpartum pediatrics.

So I laugh a lot too. I work in the P's because it's all about prevention. But I think to your point, there is a well-known concept from the genesis of an idea to full acceptance of clinical implementation, not even implementation but full clinical acceptance, takes about 17 years.

So from the time someone has a good idea that's founded in systems biology or in science to the point where there's some acceptable notion, it takes about 17 years.

So we're about 14 years into this. So by my account, we're ahead of the game, which makes me feel pretty good. But to your point, the momentum is starting, it's starting to snowball.

The North Carolina work that we are about to embark on in July is, I don't get to use names yet, but I get a talk about Big Quan's concepts. It is fully funded by an MCO.

Our cohort size is 500 pregnancies. We get to follow those kids for five years. So back to your pediatrician model to showing that when you change care within the pediatric care model too, you get better outcomes.

But what we're going to be measuring is the exploratory association between when do you intervene during this time period in pregnancy? Are these kids more resilient in terms of their health as it pertains to the allergy triad, allergies, atopy, eczema, we will be walking into the world of autism spectrum disorder too.

And then we'll also be looking at pediatric obesity up to the age of five. It will not only be funded by an MCO, it's

supported by a major four-state hospital system.

Then our recruitment will at a single site with a fully OB-GYN allopathic care team. It's the exact type of layered stakeholder engagement that's required to really meaningfully see that this model is not only implementable, it's scalable.

So that the next part of this conversation to James is the scaling. To your point, I would be the most honored person ever if in my lifetime this looked like it meaningfully was going to be part of system adoption, system-wide adoption.

We are definitely on our way, but I say this often too, is that this is hard work. Once you see it, you can't unsee it. The one piece of advice I would give to anyone, not that anyone's asking, this my unsolicited advice moment, get really good at accepting failure.

failure in the way that it presents as a no or as an not yet, or is a challenge that feels insurmountable. On the other side of that, because failure elicits fear, embarrassment, anger, And working through those feelings and those emotions, like on the other side of it is everything that you ever dreamed of.

So you have a moment, you get a chance at that very exact time when it feels like you've failed to say, do I get to turn the tide here? Do I continue to walk through it?

do i continue move through what feels darkness because it's the right thing to do? And grow baby for me has always been the thing thing do. And inevitably the things to is always the hardest.

And so the acceptance of what feels like failure is actually the most beautiful opportunity that can be given to anyone. And I just encourage anyone who wants to pioneer a concept or an idea to hold on to the other side because the side is everything you ever dreamed and hoped for and the right doors will open.

Just keep walking through it. You know, and I think that that's important to remember because after 15 years of doing this, There's many times when giving up felt like a really good idea.

Yeah, well, it's so needed. And you mentioned a phrase earlier that reminds me of my economics training, the quality adjusted life year. When you're intervening in preconception, even a small change in quality means a big shift in Quality Adjusted Life Years because you can multiply it by 60 or 70 or 80 or more.

So I think you've got a great segment of the population there. In the spirit of unqualified advice, do you feel like there's… You've spent obviously a lot more time in the functional medicine world than anyone because you grew up in it, but it seems like you've had to reposition this in a way to make it more palatable to the people that you want to work with.

I'd love to get your input on that because I see that as well. It's like, how do you speak in a language that the people who you want to help can understand?

And I would love for you to put your Yeah, well, so just to orient those who are listening who may not know this, current standard acceptable practice is to evaluate iron and folic acid, really.

Those are kind of the two core micronutrients that most obstetricians feel very comfortable speaking to, okay? But the problem, of course, with that is that they are limited in their scope, right?

Meaning that iron and folic acid certainly does not represent the myriad of micronutrient deficiencies and insufficiencies that we're seeing that impact these outcomes.

You know, James, as an example, let me give you a quick example. Just simply supplementing with DHA decreases early preterm birth and pre term birth, irrespective of measuring a biomarker, And we know that choline, a critical nutrient for cognitive health, for brain development, IQ, et cetera, especially in young children.

But if deficiencies in the mother, at 90% of insufficiency through diet, let alone through supplementation, we see a big impact of that on some of these F1 offspring outcomes, right?

But short of coming up with a long list of stuff that obstetricians don't know, my job is to language this and to teach this into what are you currently drawing?

What are currently using in your standard practice? And what insights can you find nutritionally within those markers? You know, so let's use CDC with autodifferential as an example.

You can look, albeit it's not a perfect measure, but you can utilize patterns in hemoglobin, you look at patterns of hemoglobin in a matricut and get some good insights into iron deficiency.

Those thresholds change over each trimester. But a CDC costs $3.87. You can look equally, you can at the same patterns for hemoglobin hematocrit red blood cell distribution with and mean corpuscular volume and get a good insight into macrocytic anemia.

So looking at B12 and folate status insufficiency. You can look at components of the differential looking at neutrophils, lymphocytes, platelets, and you can get composite measures of different impacts of inflammatory cascades, coagulopathies, looking overall systemic inflammation.

And you get some good insight into patterning that is associated with things like preeclampsia. things like GDM. So with less than four bucks, very quickly, a CBC with autodifferential becomes the beginning of your nutritional insight.

And then with a few additional biomarkers, I always like a CMP, and there's a lot of reasons why obstetricians don't like to pull a CMP, but a cmp equally is very cost effective.

And what I like about a cmp is within that we can get a good understanding of liver function tests. any abnormalities in AST and ALT within pregnancy or abnormal, and that in itself warrants a good evaluation.

We can look at the beginning of glucose levels, we can at some of these electrolytes, can we look a total protein, irrespective of hemodilution, it gives us a beginning a dietary understanding of macronutrient sufficiency.

And so I think it's important to bring credence to the existing frameworks that are available to us within the system that our covered by insurance, where we can amplify the utility of those by centering in around some additional education.

And that's not even discussing looking at zinc, vitamin D, carnitine free in total and maternal D to J. So what you'll find in the standard of care plus model is we're not drawing 50 to 60 to 70 biomarkers, we're not pulling big functional medicine send away kits.

We are really trying to utilize the system's strengths as they stand. Love that. Yeah. Well, look, I'm super excited to see this journey and to capture you at this moment in the journey.

And I know that the journeys continues because there's exciting things on the horizon. I just want to share my appreciation for the stick-to-itiveness that it takes to just be in it and say yes over and over again, even when it feels hard.

Look forward to following this journeys. the news of the impact hopefully will accelerate beyond your four walls and ripple out into the rest of medicine.

And I think it's really exciting to see functional medicine concepts. This is really the evolution of medical. I mean, that's beyond functional It's medicine adapting to its new environment.

The environment is nutrient insufficiencies and so medicine has to adapt to it. So what does it take to do that? Well,

you have to prove that sufficiency creates health and you've done that a number of times.

Now it's like, okay, where are the people that are most needing this and how do we get it to them? And I think you've got some really exciting pieces there and a lot of momentum.

So thank you very much for being part of the Evolution of Medicine podcast. I look forward to seeing you, hopefully, in San Diego in a few months. And we'll be doing some podcast recording there.

We'll put all the details about the study in the show notes. If you want to read more about it, you can see what's going on. Any other final thoughts about the evolution of medicine?

Seeing as this is your first time, I used to ask everyone years ago, what does it mean to you? And I'd love to get your input on that. Oh, thank you. Well, the goal for me stays the same, which is the most under leveraged aspect of our health is nutrition.

And that is never as more powerful as it is within pregnancy and that inner uterine environment. For me, that goal stays same. It's bringing personalized preventative care into the standard of care model and really gaining momentum so that all mothers, all folks who want this type of have access to it.

And that to me would be one of the most meaningful things that we could do in the evolution of medicine that has cascading effects generationally than in an area of health.

Beautiful. All right, ladies and gentlemen, this has been the Evolution of Medicine podcast. I've been here with Emily Rydbaum of Growbaby. We'll put all the details into the show notes.

Thanks, everyone, for tuning in, and we'll speak to you next time. Well, enjoy that. So that was the podcast, what an epic session. Thank you so much for turning in to the evolution of medicine podcast will be back again next week.

And thanks so